MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

To: Senate Insurance Committee Members

From: Michigan Health & Hospital Association

Date: October 15, 2012

Re: Senate Bills 1293 and 1294

The MHA has reviewed the proposal to transition Blue Cross Blue Shield of Michigan from an entity regulated under Public Act (PA) 350 of 1980 to a nonprofit mutual disability insurer regulated under the Insurance Code. Bringing Michigan's major health insurer into the same regulation as the other insurers and Health Maintenance Organizations that will be offering products on the Health Insurance Exchange is appropriate. Consumers, patients, providers, insurers and regulators are all well served by efforts to modernize the regulatory scheme and simplify the number of regulations in our system.

The MHA is not opposed to the above referenced legislation. However, there are some elements of PA 350 and the existing administrative relationship between providers and BCBSM which should transition into the Insurance Code. The MHA appreciates the effort of Senate Hune to make this transition as seamless as possible and that the surviving mutual insurer is a nonprofit entity.

Attached are amendments to address our three areas of concern.

1. The MHA recommends an amendment to protect the enforcement of the OFIR Commissioner's order of July 18, 2012. The recognition of BCBSM responsibility for addressing shortfalls in provider reimbursement related to government payment has been a common concern for MHA and its hospital members for many years. Without recognition of this in the Insurance Code, that order cannot be enforced after the BCBSM board votes to complete the merger and the existing corporate entity is no longer regulated under PA 350.

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2. With or without the Affordable Care Act (ACA), the Health Insurance Portability and Affordability Act (HIPAA) remains in place. Michigan's mechanism for assuring access to insurance without regard to pre-existing conditions to people who have been insured and lose their coverage is provided for within PA 350. The MHA recommends that this language be added to the Insurance Code and apply to all health insurers and HMOs, including the new BCBSM nonprofit mutual disability insurer.

3. The MHA believes the relationship between BCBSM and providers is enhanced by an existing administrative committee structure. While the language in the proposed legislation makes some recognition of "policies" of BCBSM being ongoing, the MHA recommends a more specific reference to the value of ongoing provider input directly to the BCBSM board of directors. This language does not require BCBSM to assign board seats to any certain provider or type of provider and it does not bind the new organization specifically to the existing committee structure.

Thank you for your attention to these suggested amendments. If you have questions about the attached language please contact Dave Finkbeiner at 517-881-8248 or Laura Appel at 517-285-2962.

The amendment below is an effort to recognize the existing contract administration advisory process that exists between BCBSM and its hospital, physician and other professional providers.

To SB No. 1294:

Amend page 2, line 26, after "**MERGER.**" by inserting "THESE **POLICIES SHALL INCLUDE, BUT ARE NOT LIMITED TO, THE PERFORMANCE BY THE SURVIVING NONPROFIT MUTUAL DISABILITY INSURER'S BOARD OF DIRECTORS OF THE CURRENT PROCESS BY WHICH HOSPITAL, PHYSICIAN, AND PROFESSIONAL PROVIDERS PROVIDE INPUT AND RECOMMENDATIONS TO THE MERGED HEALTH CARE CORPORATION'S BOARD OF DIRECTORS AND THE BOARD'S SIGNIFICANT CONSIDERATION OF THAT INPUT AND RECOMMENDATIONS.**"

Because PA 350 would not apply to any insurer if BCBSM effectuates its merger into a nonprofit mutual disability insurer, the language in PA 350 which is related to continuation of coverage under HIPAA would not be enforceable. This language has been in place since 1999.

If the Affordable Care Act (ACA) is amended in the future, Michigan will not have any reference to continuation of health care coverage. The language below lifts the existing requirement from PA 350 and puts it in the Insurance Code. It would apply to all insurers and HMOs.

To Senate Bill 1293:

Amend page 6, following line 5, by inserting:

" Sec. 3406f. (1) An insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(c) For an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section, "group" means a group health plan as defined in section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate. This section does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

~~(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and~~

~~health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:~~

~~(a) Cost of crediting prior continuous health care coverages.~~

~~(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.~~

~~(c) Types and scope of prior health care coverages that are permitted to be credited.~~

~~(d) Any exceptions or exclusions to crediting prior health care coverage~~.

~~(e) Uniform method of certifying periods of prior creditable coverage.~~ **Notwithstanding subsection (1) (a), an insurer shall not issue a policy or contract to a person eligible for individual coverage that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:**

(a) The person's most recent health coverage prior to applying for coverage with the insurer was under a group health plan.

(b) The person was continuously covered prior to the application for coverage with the insurer under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.

(c) The person is no longer eligible for group coverage and is not eligible for Medicare or Medicaid.

(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.

(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage.

Sec. 3539. (1) For an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.

(4) Except as provided in subsection (5), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(5) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(6) A health maintenance organization is not required to continue a healthy lifestyle program or to continue any incentive associated with a healthy lifestyle program, including, but not limited to, goods, vouchers, or equipment.

(7) Notwithstanding subsection (1), a health maintenance organization shall not issue a contract to a person eligible for individual coverage that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:

(a) The person's most recent health coverage prior to applying for coverage with the health maintenance organization was under a group health plan.

(b) The person was continuously covered prior to the application for coverage with the health maintenance organization under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.

(c) The person is no longer eligible for group coverage and is not eligible for Medicare or Medicaid.

(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.

(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage.

~~(7)~~ **(8)** As used in this section, "group" means a group of 2 or more subscribers.".

AMENDMENTS TO SB 1294

1. Amend page 2, line 24, after "CONTRACTS" by striking out the balance of the line through "EXIST" on line 25, and inserting a comma and "POLICIES, DEFICIENCIES, AND RESPONSIBILITIES OF THE MERGED HEALTH CARE CORPORATION THAT EXIST OR ARE PENDING".

2. Amend page 3, following line 2, by inserting:
"(5) NOTWITHSTANDING ANY MERGER UNDER THIS SECTION, THE COMMISSIONER RETAINS AUTHORITY AND RESPONSIBILITY FOR ENFORCING THE JULY 18, 2012, ORDER NO. 12-026-BC, IN THE MATTER OF THE HOSPITAL PROVIDER CLASS ACTION PLAN DETERMINATION REPORT PURSUANT TO PUBLIC ACT NO. 350 OF 1980, AND FOR TAKING SUBSEQUENT ACTIONS BASED ON THAT ORDER. THE SURVIVING NONPROFIT MUTUAL DISABILITY INSURER ASSUMES RESPONSIBILITY FOR THE MERGED HEALTH CARE CORPORATION'S RESPONSIBILITIES AS ORDERED IN THE JULY 18, 2012 COMMISSIONER'S ORDER AND FOR ANY FUTURE COMMISSIONER ORDERS THAT ADDRESS THE DEFICIENCIES AND RECOMMENDATIONS PRESENTED UNDER THE JULY 18, 2012 ORDER.".